EXHIBIT 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395618	A. BLDG: 00 B. WING:	12/07/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MULBERRY HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **021802**	**411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0000	Continued from page 1 Based on a Medicare/Medicaid Recertification, State Licensure and Civil Rights Compliance survey completed on December 7, 2023, it was determined that Mulberry Healthcare and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

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F 0000	Continued from page 2	F 0000		
F 0580 SS=D		F 0580		

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F 0580 SS=D	Continued from page 3 483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this	F 0580	Resident R4 accepted a suppository on the evening of December 6, 2023, and his bowels moved effectively. Resident R4 consistently exercises his right to refuse medications and care, and the staff work with him to provide needed services as able and educate him on consequences. Going forward a daily bowel assessment by the Registered Nurse will be completed starting on day 3 of no bowel movement if the resident refuses bowel protocol with notification to the physician. Any resident noted to have refusal of medications will have physician notification completed to address any potential need for changes in orders. The nursing staff will be educated regarding refusal of medications and care to first educate the resident on potential consequences of refusals and then notify physician for any change in orders. Any documented refusals will be reviewed during clinical meeting to ensure proper education and notifications have been completed.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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F 0580 SS=D	Continued from page 4 section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:	F 0580	Monitoring 5 days per week x 4 weeks, then monthly x 2. Results to Quality Assurance.	

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F 0580 SS=D	Continued from page 5 Based on review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician was notified of a resident's change in condition for one of 22 residents reviewed (Resident 4). Findings include: The facility's policy for refusal of care, dated September 28, 2023, indicated that the attending physician must be notified of refusal of treatment in a time frame determined by the resident's condition and potential serious consequences of the refusal. The facility's bowel protocol includes for the daylight nurse to administer Milk of Magnesia after nine shifts of no bowel movement, and if ineffective, the evening shift nurse is to administer a suppository. If the suppository is ineffective, the nurse the next morning is to administer a Fleets enema. If the Fleets enema and all other interventions are	F 0580		

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F 0580 SS=D	Continued from page 6	F 0580		

ineffective, the registered nurse is to assess the resident and call the physician.

A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated October 18, 2023, revealed that the resident was cognitively intact, was independent for personal hygiene needs, had an indwelling catheter, had a pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure), and had diagnoses that included paraplegia (paralysis of legs and lower body).

A review of the bowel records for Resident 4, dated November and December 2023, revealed that as of December 6, 2023, the last bowel movement the Resident had was on November 22, 2023.

A nursing note for Resident 4, dated November 30, 2023, at 3:59 a.m. revealed that the resident had not moved his bowels in over seven days and was refusing the bowel protocol. A nursing note, dated

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F 0580 SS=D	Continued from page 7 December 1, 2023, at 4:04 a.m., revealed that the resident had not had a bowel movement in almost seven days; however, he refused the bowel protocol and was aware of the consequences. A nursing note, dated December 6, 2023, at 4:11 a.m., revealed that the resident did not have a bowel movement and was refusing the bowel protocol stating, "We are beyond that point," and requested that the fecal material be digitally removed. A review of nursing and physician's progress notes for Resident 4 for November and December 2023 revealed no documented evidence that the physician was notified that the resident had been refusing the bowel protocol and had not had a bowel movement in 13 days. Interview with Resident 4 on December 6, 2023, at 9:16 a.m. revealed that he believed he had not had a bowel movement in about three weeks and was very uncomfortable. He agreed that he refused to take Milk of Magnesia and is not against taking suppositories or enemas but had refused stating that	F 0580		

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F 0580 SS=D	Continued from page 8 the only thing that works is digital extraction, and the facility will not allow that procedure to be done. Interview with the Nursing Home Administrator on December 7, 2023, at 9:48 a.m. confirmed that the physician was not notified that the resident was refusing the bowel protocol and had not had a bowel movement in 13 days. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0580		
F 0641 SS=D		F 0641		

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F 0641 SS=D	Continued from page 9 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	The Minimum Data Set assessments noted are not able to be retroactively corrected at this time. An education will be completed by the Regional Director of Clinical Reimbursement for the Interdisciplinary Team to ensure understanding of the resident interview process and proper completion of the Minimum Data Set. A random audit of Minimum Data Set assessments will be completed weekly x4 to ensure proper completion of Sections C and D. Audits completed by the Registered Nurse Assessment Coordinator will be reported through the quality assurance committee.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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F 0641 SS=D	Continued from page 10 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for three of 22 residents reviewed (Residents 5, 11, 40). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, revealed that Section B0700 (make self understood) should be coded with either usually understood, sometimes understood, or rarely/never understood, and Section B0800 (ability to understand other) should be coded with either usually understands, sometimes understands, or rarely/never understands. Section C0100 (should brief interview for mental status be conducted) should be completed if the resident is at least	F 0641		

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F 0641 SS=D	Continued from page 11 sometimes understood verbally, in writing, or using another method. Section D (Mood) should be completed if the resident is at least sometimes understood verbally, in writing, or using another method. A significant change MDS for Resident 5, dated September 29, 2023, revealed that section B0700 was coded usually understood and Section B0800 was coded usually understands. Section C0100 was coded (no), indicating that the assessment was not completed because the resident was rarely or never understood. Section D0100 was coded (no), indicating that the assessment was not completed because the resident was rarely or never understood. An annual MDS for Resident 11, dated August 30, 2023, revealed that section B0700 was coded usually understood and Section B0800 was coded usually understands. Section C0100 was coded (no), indicating that the assessment was not completed because the resident was rarely or never	F 0641		

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F 0641 SS=D	Continued from page 12 understood. Section D0100 was coded (no), indicating that the assessment was not completed because the resident was rarely or never understood. A quarterly MDS for Resident 40, dated August 1, 2023, revealed that section B0700 was coded usually understood and section B0800 was coded as sometimes understands. Section C0100 was coded as (no), indicating that the assessment was not completed because the resident was rarely or never understood. Section D0100 was coded (no), indicating that the assessment was not completed because the resident was rarely or never understood. A quarterly MDS for Resident 40, dated October 4, 2023, revealed that section B0700 was coded as usually understood and section B0800 was coded as sometimes understands. Section C0100 was coded as (no), indicating that the assessment was not completed because the resident was rarely or never understood. Section D0100 was coded (no),	F 0641		

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F 0641 SS=D	Continued from page 13 indicating that the assessment was not completed because the resident was rarely or never understood. Interview with the Social Worker on December 7, 2023, at 1:34 p.m. confirmed that section C0100 and Section D0100 of Resident 5's significant change MDS assessment for September 29, 2023; Resident 11's annual MDS assessment for August 30, 2023; Resident 40's quarterly MDS assessment dated August 1, 2023; and Resident 40's quarterly MDS assessment, dated October 4, 2023, were coded incorrectly and that the residents should have had a brief interview for mental status completed and a mood assessment completed but did not. 28 Pa. Code 211.5(f) Clinical records.	F 0641		
F 0657 SS=D		F 0657		

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F 0657 SS=D	Continued from page 14 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	The care plan for Resident R2 was updated to include nonskid tape by the bedside. Resident R35's care plan was updated to reflect the family's desired plan of care. A review of resident incidents for the last 30 days will be completed to ensure any new intervention has been updated in the care plans. New incidents will be reviewed at the clinical meeting to review any new interventions indicated. The Registered Nurse Assessment Coordinator or designee will verify new interventions have been updated in the care plan once the intervention has been completed in the resident room. A monthly audit of incidents will be completed by the Director of Nursing or designee to verify that new interventions added related to incidents have been added to the plan of care and reviewed at Quality Assurance. Audits will be reviewed daily x5 for 2 weeks then weekly x2, then monthly x2 with results to the quality assurance committee.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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F 0657 SS=D	Continued from page 15 Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in residents' care needs for two of 22 residents reviewed (Residents 2, 35). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated September 1, 2023, indicated that the resident was cognitively impaired, needed limited assistance with transfers and ambulation, and had no fall history. A nurses note, dated September 24, 2023, at 4:45 a.m. revealed that Resident 2's alarm was sounding, and the licensed practical nurse found the resident on the floor in front of the recliner. The intervention for the fall was for anti-skid tape to be placed on the floor in front of the resident's recliner. Observations on December 6, 2023, at 12:28 p.m.	F 0657		

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MULBERRY HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **021802**	**411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0657 SS=D	Continued from page 16 revealed that there was anti-skid tape on the floor bedside Resident 2's bed. There was no anti-skid tape observed in front of resident's recliner. An administrator's note, dated December 6, 2023, at 2:38 p.m. revealed that the interdisciplinary team met after Resident 2's fall on September 24, 2023, and had discussed placing anti-skid tape in front of the resident's recliner, but after discussion with family, they decided to place the anti-skid tape on the floor by the resident's bed. There was no documented evidence that Resident 2's care plan regarding fall prevention was revised to reflect the placement of anti-skid tape on the floor by the resident's bed. Interview with the Nursing Home Administrator and the Director of Nursing on December 6, 2023, at 3:06 p.m. confirmed that Resident 2's care plan for fall prevention was not revised to reflect the intervention for anti-skid tape on the floor by the resident's bed.	F 0657		

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F 0657 SS=D	Continued from page 17 An annual MDS for Resident 35, dated September 6, 2023, indicated that the resident was cognitively intact, used oxygen, and had diagnoses that included congestive heart failure (occurs when the heart does not pump blood as well as it should), atrial fibrillation (irregular heart rhythm), and the presence of a cardiac pacemaker (a small battery-powered device that prevents the heart from beating too slowly). Review of Resident 35's clinical record revealed no physician's order to have pacemaker checks or a follow up with a cardiologist. Review of resident's cardiac care plan indicated that pacemaker checks were to be done as ordered. Interview with the Nursing Home Administrator on December 7, 2023, at 2:19 p.m. revealed that Resident 35's family did not want to have pacemaker checks done and did not want him to follow up with cardiology. The Nursing Home Administrator confirmed that the resident's care plan should have been revised to remove the intervention	F 0657		

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F 0657 SS=D	Continued from page 18 for pacemaker checks and it was not. 28 Pa. Code 211.11(d) Resident care plan.	F 0657		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 19 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Resident R4 accepted a suppository on the evening of December 6, 2023, and his bowels moved effectively. Resident R4 consistently exercises his right to refuse medications and care, and the staff work with him to provide needed services as able and educate him on consequences. Going forward a daily bowel assessment by the Registered Nurse will be completed starting on day 3 of no bowel movement if the resident refuses bowel protocol with notification to the physician. Any resident noted to have refusal of medications will have physician notification completed to address any potential need for changes in orders. The nursing staff will be educated regarding refusal of medications and care to first educate the resident on potential consequences of refusals and then notify physician for any change in orders. Any documented refusals will be reviewed during clinical meeting to ensure proper education and notifications have been completed.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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F 0684 SS=D	Continued from page 20 [redacted]	F 0684	Audits will be completed daily x5 days for 2 weeks, then weekly x 2 weeks, then monthly x 2 with results to quality assurance committee.	
F 0686 SS=D		F 0686		

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F 0686 SS=D	Continued from page 21 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	Treatment Records from previous months can not be retroactively completed at this time for these individuals. Residents receiving current wound care will be checked by the nursing supervisor at the completion of each shift to ensure treatments and documentation are done for the shift. Licensed nurses will be educated on the importance of completing all treatments and documentation each shift. Nursing administration will review documentation at clinical meeting 5 days per week to ensure completion of Treatments Records and address any discrepancies as needed. Audits will be completed daily x 2 weeks, weekly x 2 weeks, then monthly x 2 with results to the quality assurance committee.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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F 0686 SS=D	Continued from page 22 Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure that treatments for pressure ulcers were provided as ordered by the physician for two of 22 residents reviewed (Residents 4, 22). Findings include: The facility's policy regarding dressing and wound documentation, dated September 28, 2023, indicated that wound care/dressings and refusals should be documented on the resident's medical record, treatment sheet or designated wound form. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated October 18, 2023, revealed that the resident was cognitively intact, was independent for personal hygiene needs, had an indwelling catheter, had a pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure), and had diagnoses that	F 0686		

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F 0686 SS=D	Continued from page 23 included paraplegia (paralysis of legs and lower body). Physician's orders for Resident 4, dated September 22, 2023; October 23, 2023; and October 24, 2023, included an order for the resident's right gluteal (buttocks) pressure ulcer to be cleansed with normal saline and silver alginate (highly absorbent wound dressing) applied to the wound base and secured with a bordered foam (foam dressing with an adhesive border) dressing daily and as needed for dislodgement. Physician's orders for Resident 4, dated October 12, 2023, and November 4, 2023, included orders for the resident's left trochanter (upper part of the of the femur near its joint with the hip bone) pressure ulcer was to be cleansed with 0.125 percent Dakin's solution (wound cleanser), Gentamicin (antibiotic) applied inside the wound, the wound packed with iodine packing strip (used to absorb drainage in a wound), leaving approximately one inch outside the wound, and covered with a superabsorbent dressing	F 0686		

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F 0686 SS=D	Continued from page 24 daily and as needed for wound care. Physician's orders, dated October 27, 2023, and November 4, 2023, included an order for the resident's right gluteal pressure ulcer to be cleansed with normal saline, medical grade honey applied to the base of the wound, and covered with bordered gauze daily and as needed for dislodgement. Physician's orders, dated November 16, 2023, included an order for the resident's right gluteal pressure ulcer to be cleansed with normal saline, hydrocolloid (used to promote healing of wounds) applied to the base of the wound and secured with hydrocolloid every Monday and Thursday evening and as needed for dislodgement. Review of Resident 4's Treatment Administration Record (TAR) dated October and November 2023 revealed no documented evidence that the resident's dressing to his right gluteal pressure ulcer was completed or refused on October 15, November 5, and November 23.	F 0686		

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F 0686 SS=D	Continued from page 25 Review of Resident 4's TAR, dated October 2023; November 2023; and December 2023 revealed no documented evidence that the resident's dressing to his left trochanter pressure ulcer was completed or refused on October 15 and 22, November 5, November 23, and December 3. Interview with the Director of Nursing on December 7, 2023, at 9:48 a.m. revealed there was no documented evidence that Resident 4's pressure wound treatments were administered or refused on the above-mentioned dates and times. A quarterly MDS assessment for Resident 22, dated November 8, 2023, revealed that the resident was cognitively intact, required moderate assistance of staff for daily care needs, and had a Stage 3 pressure ulcer (full thickness tissue loss with damage below the skins surface). Physician's orders for Resident 22, dated September 21, 2023, included an order for the right	F 0686		

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F 0686 SS=D	Continued from page 26 hip to be cleansed with normal saline solution (mixture of salt and water), apply medical grade honey and calcium alginate (a highly absorbent dressing) to base of wound, and cover with bordered foam dressing (provides absorption and insulation) daily. Physician's orders for Resident 22, dated November 30, 2023, included an updated order to cleanse with NSS, apply skin prep (skin protectant) to wound daily, and leave open to air. A wound note, dated November 29, 2023, revealed that Resident 22 had an improving pressure ulcer on his right hip that measured 0.3 x 0.3 x 0 centimeters. Resident 22's TAR's for November and December 2023 revealed no documented evidence that the treatments to the right hip pressure wound were completed or refused on November 10 and December 1, 2023.	F 0686		

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F 0686 SS=D	Continued from page 27 Interview with the Director of Nursing on December 7, 2023, at 12:52 p.m. confirmed that there was no documented evidence that Resident 22's treatments to the right hip were completed on the above dates as ordered by the physician. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0686		
F 0688 SS=D		F 0688		

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F 0688 SS=D	Continued from page 28 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	Resident R11 was confirmed by therapy to continue to encourage use of PRAFO boots (soft boots applied to feet to prevent foot drop) as tolerated. A physician order was added to the Treatment Record so that licensed staff will be accountable to document use or refusal of the boots each shift. A review of nurse aide tasks will be compared with therapy to ensure recommended devices are listed in the Treatments Records and that licensed staff are accountable to sign for use or refusal of the recommended device. Nursing staff will be educated on the importance of encouraging use of all recommended devices and completion of documentation. Nursing administration will review documentation at clinical meeting 5 days per week to ensure completion of Treatment Records and address any discrepancies as needed. Audits will be completed and documented daily x5 for 2 weeks, then weekly x2 then monthly x2 with results to quality assurance committee.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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F 0688 SS=D	Continued from page 29 Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that physician-ordered contracture management services were provided as care planned for one of 22 residents reviewed (Resident 11). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 11, dated August 30, 2023, revealed that the resident was usually able to make herself understood and was usually able to understand others, was dependent on staff for her daily care needs, and had diagnoses that included dementia. Current physician's orders for Resident 11 included an order for the resident to have bilateral (both sides) PRAFO (provides support to keep the ankle aligned to treat muscle weakness) foot/ankle boots	F 0688		

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F 0688 SS=D	Continued from page 30 applied when getting out of bed and removed when returning to bed, leaving on for six to eight hours or to the resident's tolerance. A care plan for Resident 11, dated September 30, 2022, revealed that the resident had a self-care deficit caused by weakness and decreased mobility, and had an intervention that included bilateral PRAFO foot/ankle boots to be applied when getting out of bed and removed when returning to bed, leaving on for six to eight hours or to the resident's tolerance. Observations or Resident 11 on December 4, 2023, at 12:35 p.m. revealed that the resident was sitting in her chair with her legs elevated on a footrest and no PRAFO boots on her feet. An interview with the therapy manager on December 7, 2023, at 12:02 p.m. revealed that the PRAFO boots ordered for Resident 11 were to be applied for contracture (tightening of muscles, tendons or ligaments that prevents normal body	F 0688		

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F 0688 SS=D	Continued from page 31 movement) management. Interview with the Nursing Home Administrator on December 6, 2023, at 2:53 p.m. confirmed that there was no documented evidence to indicate that the bilateral PRAFO boots were being applied daily to Resident 11 as ordered and care planned. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0688		
F 0689 SS=D		F 0689		

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F 0689 SS=D	Continued from page 32 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	No adverse issues were noted to Resident R20 or R34 related to wheelchair movement. A policy was written to include the use of footrests on wheelchairs when residents are being pushed by staff for mobilization. All staff will be educated on the use of wheelchair leg rests when a resident is being pushed by a staff member. Assistant Director of Nursing or designee will monitor random observation of staff when pushing wheelchairs daily x2 weeks, then weekly x 2 weeks, then monthly. Results to Quality Assurance.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **12/29/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395618	A. BLDG: 00 B. WING:	12/07/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MULBERRY HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **021802**	**411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767**

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F 0689 SS=D	Continued from page 33 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that each resident received assistance devices to prevent accidents for two of 22 residents reviewed (Residents 20, 34). Findings include: An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 20, dated October 23, 2023, revealed that the resident was cognitively impaired, was dependent on staff for daily care needs including transfers and locomotion, and had diagnoses that included dementia. Observations of Resident 20 on December 4, 2023, at 12:20 p.m. revealed that the resident was pulled in her wheelchair from the hallway to the dining area by the speech therapist. The wheelchair had no footrests on it to prevent the resident from dragging her feet. An interview with the speech therapist at	F 0689		

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F 0689 SS=D	Continued from page 34 that time revealed that the resident should have had footrests on her chair but did not, so she pulled the resident so she could observe her feet. A quarterly MDS assessment for Resident 34, dated November 15, 2023, revealed that the resident was usually understood and usually understood others, required partial moderate assist for transfers and wheelchair mobility, and had diagnosis that included dementia. Observations of Resident 34 on December 4, 2023, at 11:30 a.m. revealed that the resident was transported in a wheelchair from her bedroom to the shower room by Nurse Aide 1. The wheelchair had no footrests on it to prevent the resident from dragging her feet. An interview with Nurse Aide 1 at that time confirmed that she should not have transported the resident in her wheelchair without footrests. An interview with the Nursing Home Administrator on December 4, 2023, at 1:23 p.m. confirmed that	F 0689		

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F 0689 SS=D	Continued from page 35 footrests should have been used when transporting Residents 20 and 34. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0689		
F 0690 SS=C		F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0690 SS=C	Continued from page 36 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	Resident R4 had his catheter changed upon his agreement on 12/10/23. Resident R18 had her catheter changed to match current orders of 18 Fr/10cc. All residents with Indwelling catheters will be assessed to ensure sizes used are correct based on physician orders, and monthly changes are completed as per the Treatment Record. Any refusals will be followed the next day until completed and documented. Licensed Nurses will be educated on importance of using supplies as per physician orders and timely completion as specified by the Treatment Record for each resident. Nursing administration will review documentation at clinical meeting 5 days per week to ensure completion of Treatment Records and address any discrepancies as needed. Audits will be completed and documented 5 days per week x2 weeks, then weekly x2 , then monthly x2 with results to the quality assurance committee.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0690 SS=C	Continued from page 37 This REQUIREMENT is not met as evidenced by:	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395618	A. BLDG: __00_____ B. WING: _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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STATE LICENSE NUMBER: **021802**	

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F 0690 SS=C	Continued from page 38 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to provide appropriate care for two of 22 residents reviewed who had an indwelling urinary catheter (Residents 4, 18). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated October 18, 2023, revealed that the resident was cognitively intact, was independent for personal hygiene needs, had an indwelling catheter (a tube placed and held in the bladder to drain urine), and had diagnosis that included paraplegia (paralysis of the legs and lower body) and neurogenic bladder (problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition). Physician's orders for Resident 4, dated February 3, 2023, included an order for the resident's foley (type of indwelling catheter) catheter to be changed	F 0690		

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F 0690 SS=C	Continued from page 39 every 28 days. A nursing note for Resident 4, dated October 13, 2023, at 5:08 a.m. revealed that the resident refused to have his foley catheter changed. There was no documented evidence to indicate that Resident 4 had his foley catheter changed or was offered to have it changed during the next 28 days. A nursing note for Resident 4, dated November 10, 2023, at 00:01 a.m. revealed that the resident had refused to have his foley catheter changed that night but requested that it be changed the next day. As of December 7, 2023, there was no documented evidence to indicate that Resident 4 had his foley catheter changed or was offered to have it changed since his request on November 10, 2023. Interview with Resident 4 on December 6, 2023, at 9:16 a.m. revealed that he remembered requesting to have his foley catheter changed; however, no one has approached him to change it since his request. The resident did not recall the last time his foley catheter was changed.	F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0690 SS=C	Continued from page 40 Interview with Nursing Home Administrator on December 7, 2023, at 9:48 a.m. confirmed that there was no documented evidence that the resident was reapproached and offered the foley catheter change after he refused on the dates identified above and he should have been, and there was no documented evidence that Resident 4's foley catheter was changed every 28 days as ordered by the physician. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 18, dated September 22, 2023, revealed that the resident was cognitively intact, required extensive assistance of staff for personal hygiene needs, had an indwelling catheter (a tube placed and held in the bladder to drain urine), and had diagnoses that included neurogenic bladder (problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition).	F 0690		

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F 0690 SS=C	Continued from page 41 Physician's orders for Resident 18, dated August 10, 2022, included an order for the resident's foley catheter to be changed once a month with an 18 French/10 cc balloon (size of indwelling catheter). A nursing note for Resident 18, dated December 6, 2023, at 12:20 a.m., revealed that the foley catheter was changed and replaced with a 16 French/10 cc balloon, the resident tolerated it well, and the catheter was patent and draining pale yellow urine. Interview with the Nursing Home Administrator on December 7, 2023, at 1:48 p.m. confirmed that Resident 18's catheter should have been replaced with an 18 French/10cc balloon catheter as ordered by the physician and it was not. 28 Pa. Code 211.12(d)(3)(5) Nursing services.	F 0690		
F 0732 SS=C		F 0732		

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F 0732 SS=C	Continued from page 42 483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 0732	The Facility Staffing Posting was updated immediately at the time of the survey. The new night shift Registered Nurse was educated on the process for completing the Facility Staffing Posting and updating each morning. All staff were educated on the Facility Staffing Posting and that it is to be updated each day. The Nursing Home Administrator or designee will monitor the Facility Staffing Posting each day to ensure updating and address changes or concerns as needed. Daily postings will be kept on file for review upon request. Audits will be completed and documented 5 days per week x2, then weekly x2, then monthly x2 with results to quality assurance.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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F 0732 SS=C	Continued from page 43 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by:	F 0732		

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F 0732 SS=C	Continued from page 44 Based on observations and staff interviews, it was determined that the facility failed to ensure that the required nursing staffing information was posted daily. Findings include: Observations on December 6, 2023, at 9:27 a.m. revealed that the posted nursing staffing information was dated for Monday, December 4, 2023. Interview with Licensed Practical Nurse 2 on December 6, 2023, at 9:27 a.m. confirmed that the staffing information posted at the main entrance was the staffing information for December 4, 2023. Interview with the Nursing Home Administrative on December 6, 2023, at 3:58 p.m. confirmed the posting was old and that staffing hours were to be posted daily. 28 Pa. Code 201.18(b)(1)(3) Management.	F 0732		

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F 0732 SS=C	Continued from page 45	F 0732		
F 0755 SS=D	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and	F 0755	Resident R5 was not adversely affected and received her pain medication as needed. The licensed practical nurse received education/disciplinary action for not ensuring the pain medication was signed on both the Controlled drug record as well as the Medication Record. An audit of residents receiving controlled substances over the last 30 days will be completed to assess comparison of controlled substance records and Medication Records to ensure both are signed as per policy. An education will be completed for all licensed nurses regarding signing both the Controlled drug record and the Medication Record for each individual receiving controlled substances. The Director of Nursing or designee will complete an audit weekly x4 then monthly x2 to compare Medication Records and Controlled Drug records to ensure matching information. Results will be provided to the quality assurance committee.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=D	Continued from page 46 periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0755 SS=D	Continued from page 47 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 22 residents reviewed (Resident 5). Findings include: A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated September 29, 2023, indicated that the resident was usually understood and could usually understand others, required extensive assistance for personal hygiene needs, was taking pain medication as needed, and had diagnoses that included dementia. Physician's orders for Resident 5, dated April 28, 2023, included an order for the resident to receive 5/325 milligrams (mg) of Oxycodone-Acetaminophen (a controlled pain medication) every eight hours as needed for pain.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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MULBERRY HEALTHCARE AND REHABILITATION CENTER	**411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767**
STATE LICENSE NUMBER: **021802**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0755 SS=D	Continued from page 48 Review of the controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug) for Resident 5 for September, October, and November 2023 indicated that a dose of Oxycodone-Acetaminophen was signed out on September 23 at 12:40 p.m., September 28 at 8:00 a.m., September 30 at 9:40 a.m., October 8 at 9:10 a.m., October 11 at 9:00 a.m., October 27 at 9:00 a.m., and November 23 at 7:43 a.m. Review of Resident 5's Medication Administration Record (MAR) and nursing notes revealed no documented evidence that the signed-out doses of Oxycodone-Acetaminophen were administered to the resident on these dates and times. Interview with the Director of Nursing on December 7, 2023, at 2:55 p.m. confirmed that there was no documented evidence in Resident 5's clinical records to indicate that the signed-out doses of Oxycodone-Acetaminophen were administered to the resident on the above-mentioned dates and	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395618	A. BLDG: 00 B. WING:	12/07/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MULBERRY HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **021802**	**411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767**

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F 0755 SS=D	Continued from page 49 times. 28 Pa. Code 211.9(h) Pharmacy services. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0755		
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 0761	The Licensed Practical Nurse was educated/disciplined regarding leaving the medication cart unlocked and unattended. All licensed nurses were educated on the importance of locking medication carts when not being directly attended. Assistant Director of Nursing or designee will make random observations of medication carts to ensure locking when not attended. Observations will be completed daily x2 weeks, then weekly x2 weeks, then monthly with results to quality assurance.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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F 0761 SS=D	Continued from page 50 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761		

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F 0761 SS=D	Continued from page 51 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly secured in the medication cart. Findings include: The facility's policy regarding the security of the medication cart, dated September 28, 2023, indicated that the nurse was to secure the medication cart during the medication pass to prevent unauthorized entry and the medication cart was to be securely locked at all times when out of the nurse's view. Observations on December 4, 2023, at 3:56 p.m. revealed that a medication cart (east cart) in the hallway was unattended by staff members and was unlocked. Interview with Licensed Practical Nurse 3 on December 4, 2023, at 3:58 p.m. confirmed that her medication cart was unsecured and should have	F 0761		

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F 0761 SS=D	Continued from page 52 been locked. Interview with the Director of Nursing on December 4, 2023, at 4:00 p.m. confirmed that the medication cart should have been locked when unattended. 28 Pa. Code 211.9(a)(1) Pharmacy services. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0761		
F 0812 SS=D		F 0812		

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F 0812 SS=D	Continued from page 53 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	Noted undated items on December 4, 2023 were discarded at the time of the survey. An audit of the kitchen freezer and walk in cooler was conducted by the Dietary Manager to ensure all items are secured and dated. An education was conducted for all dietary staff members regarding dating policy for the kitchen. Dietary Manager or designee will audit freezer and walk in cooler to ensure all needed items are sealed and dated. Observations will be completed daily x2 weeks, then weekly x2 weeks, then monthly with results to quality assurance.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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F 0812 SS=D	Continued from page 54 Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food in accordance with professional standards for food service safety by failing to properly label and date refrigerated and frozen foods. Findings include: The facility's policy regarding food storage, dated September 28, 2023, revealed that leftover food was to be stored in covered containers or wrapped carefully and securely. Each item was to be clearly labeled and dated before being refrigerated or frozen. Observations in the kitchen's walk-in refrigerator on December 4, 2023, at 10:02 a.m. revealed an unopened package of cheese that was not in the original container and not dated, and an opened bag of cheese that was not sealed, opened to air, and not dated.	F 0812		

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F 0812 SS=D	Continued from page 55 Observations in the kitchen's walk-in freezer on December 4, 2023, at 10:04 a.m. revealed a bag of frozen chicken opened to air and not sealed. Observations in the reach-in freezer on December 4, 2023, at 10:07 a.m. revealed unopened packages of frozen pancakes and French toast that were not in their original container and not labeled or dated. Interview with the Dietary Manager, after each observation, confirmed that all foods in the refrigerator and freezer are to be labeled and dated and all opened packages are to be sealed and not open to air. 28 Pa. Code 211.6(f) Dietary services.	F 0812		
F 0842 SS=D		F 0842		

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F 0842 SS=D	Continued from page 56 483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Medication and Treatment Records from previous months can not be retroactively completed at this time for these individuals. Residents receiving current Intravenous therapy and residents with catheters will be checked by the nursing supervisor at the completion of each shift to ensure medications/treatments and documentation are done for the shift. Licensed nurses will be educated on the importance of completing all treatments and documentation each shift and ensuring all medications have been provided and documented. Nursing administration will review documentation at clinical meeting 5 days per week to ensure completion of Medication and Treatment Records and address any discrepancies as needed. Audits will be completed and documented five days per week x 2 weeks, then weekly x2, then monthly x2 with results to quality assurance.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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F 0842 SS=D	Continued from page 57 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842		

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F 0842 SS=D	Continued from page 58 This REQUIREMENT is not met as evidenced by:	F 0842		

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F 0842 SS=D	Continued from page 59 Based on review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for two of 22 residents reviewed (Residents 18, 42). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 18, dated September 22, 2023, revealed that the resident was cognitively intact, required extensive assistance of staff for personal hygiene needs, had an indwelling urinary catheter (a tube placed and held in the bladder to drain urine), and had diagnoses that included neurogenic bladder (problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition). Physician's orders for Resident 18, dated August 10, 2022, included an order for the resident's	F 0842		

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F 0842 SS=D	Continued from page 60 urinary catheter to be changed once a month with an 18 French/10 cc balloon (size of indwelling catheter). Review of the October and November 2023 Treatment Administration Record (TAR) for Resident 18 revealed that there was no documented evidence that the foley catheter was changed monthly as ordered by the physician. Interview with the Director of Nursing on December on December 6, 2023, at 2:00 p.m. revealed that she changed the foley catheter as ordered but never got around to documenting it because she was busy training new staff. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 42, dated November 16, 2023, revealed that the resident was cognitively intact, independent to supervision with care needs, had a surgical wound to the left foot, and had diagnoses that included Diabetes Mellitus,	F 0842		

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F 0842 SS=D	Continued from page 61 cellulitis (infection) to left lower limb, and sepsis. Physician's orders for Resident 42, dated November 9, 2023, included an order to flush the peripherally inserted central catheter (PICC-a type of central venous catheter inserted into a vein and used long-term for the administration of fluids and/or medications) with 10 cc (cubic centimeters) of normal saline every shift. Physician's orders for Resident 42, dated November 16, 2023, included an order for 1750 milligrams (mg) of vancomycin HCL (an antibiotic medication) one time a day intravenously (IV) via a PICC. Review of the Medication Administration Record (MAR) for Resident 42 for November and December 2023 revealed that there was no documented evidence that the vancomycin was administered on November 20, 2023, and December 5, 2023, and no documented evidence that the PICC line was flushed on the 6:00 a.m. to	F 0842		

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F 0842 SS=D	Continued from page 62 2:00 p.m. shift for December 5, 2023; on the 2:00 p.m. to 10:00 p.m. shift for November 10, 14, 19, 21, 23 and 29, 2023; and on 10:00 p.m. to 6:00 a.m. shift for November 29, 2023, per physician's orders. An interview with the Nursing Home Administrator on December 7, 2023, at 10:40 a.m. revealed that Resident 42's vancomycin and normal saline flushes were being administered as ordered; however, documentation on the MAR was incomplete. The Nursing Home Administrator confirmed that documentation should have been present for the vancomycin and normal saline flush administration on the above dates and shifts and it was not. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.12(d)(5) Nursing services.	F 0842		
F 0867 SS=D		F 0867		

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F 0867 SS=D	Continued from page 63 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including	F 0867	All cited deficiencies will be followed during Quality Assurance meetings. Various designated department managers will provide auditing results for review during Quality Assurance meetings. All staff will be educated on the various deficiencies and categories of repeated areas of concern. The Nursing Home Administrator or designee will collaborate with department managers regarding areas of concerns and continued audits to ensure continued focus in these areas. Continued focus and following of audits with adjustments as needed to maintain ongoing compliance.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **12/29/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395618	A. BLDG: __00_____ B. WING: _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
MULBERRY HEALTHCARE AND REHABILITATION CENTER	**411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767**
STATE LICENSE NUMBER: **021802**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0867 SS=D	Continued from page 64 the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the	F 0867		

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F 0867 SS=D	Continued from page 65 incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F 0867		

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F 0867 SS=D	Continued from page 66 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	F 0867		

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F 0867 SS=D	Continued from page 67 Based on review of the facility's plans of correction and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) surveys ending March, 10, 2023; December 29, 2022; and December 12, 2022, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending December 7, 2023, identified repeated deficiencies related to physician notification; quality of care; proper storage and labeling of medications; food procurement, storing, preparing and serving	F 0867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0867 SS=D	Continued from page 68 food under sanitary conditions; and resident records. The facility's plan of correction for a deficiency regarding physician notification cited during the surveys ending March 10, 2023, and December 29, 2022, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F580, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding physician notification. The facility's plan of correction for a deficiency regarding quality of care, cited during the surveys ending March 10, 2023, and December 12, 2022, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the QAPI committee was ineffective in correcting deficient	F 0867		

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F 0867 SS=D	Continued from page 69 practices related to quality of care. The facility's plan of correction for a deficiency regarding proper storage and labeling of medications, cited during the survey ending March 10, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F761, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding proper storage and labeling of medications. The facility's plan of correction for a deficiency for food procurement, storing, preparing and serving food under sanitary conditions, cited during the survey ending March 10, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding	F 0867		

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F 0867 SS=D	Continued from page 70 food procurement, storing, preparing and serving food under sanitary conditions. The facility's plan of correction for a deficiency for resident records cited during the survey ending December 29, 2022, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F842, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding resident records. Refer to F580, F684, F761, F812, F842. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.	F 0867		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 71 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Resident R22 's catheter bag was secured off the floor at the time of the survey. All resident's utilizing indwelling foley catheters were assessed to ensure bags were secured and not touching the floor. Staff was educated on proper securement of catheter bags to ensure elevation off of the floor. Director of Nursing or designee will complete auditing of resident catheter bags to ensure proper placement daily x2 weeks, then weekly x2 weeks, then monthly review ongoing. Any discrepancies will be addressed at the time of the observation. Results will be provided at the Quality Assurance meetings.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **12/29/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 72 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 73	F 0880		

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F 0880 SS=D	Continued from page 74 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed while providing catheter care for one of 22 residents reviewed (Resident 22). Findings include: The facility's policy regarding catheter care, dated September 28, 2023, indicated that the catheter tubing and drainage bag were to be kept off the floor to prevent catheter-associated urinary tract infections. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 22, dated November 8, 2023, revealed that the resident was alert and oriented, and had diagnoses that included neuromuscular dysfunction of the bladder (a condition that results in the bladder not filling or	F 0880		

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F 0880 SS=D	Continued from page 75 emptying correctly). The resident's care plan, dated September 19, 2023, indicated the use of an indwelling catheter. Physician's orders for Resident 22, dated November 16, 2023, included an order for the resident to receive Keflex (an antibiotic) for a urinary tract infection. Observations on December 5, 2023, at 11:05 a.m. revealed that the catheter was in a dignity bag lying on the floor underneath the left side of Resident 22's bed. The resident's left stocking foot was touching the dignity bag. Interview with Nurse Aide 4 on December 5, 2023, at 11:19 a.m. revealed that the catheter was in a dignity bag and was lying directly on the floor underneath the resident's bed. Interview with the Director of Nursing on December 5, 2023, at 11:25 a.m. confirmed that the catheter bag was lying on the floor under Resident 22's bed	F 0880		

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F 0880 SS=D	Continued from page 76 and should not have been. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0880		

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P 5380	Resident care policies. (d) The policies shall be designed and implemented to ensure that the resident receives proper care to prevent pressure sores and deformities; that the resident is kept comfortable, clean and well-groomed; that the resident is protected from accident, injury and infection; and that the resident is encouraged, assisted and trained in self-care and group activities. This REGULATION is not met as evidenced by:	P 5380	No adverse issues were noted to Resident R20 or R34 related to wheelchair movement. A policy was written to include the use of footrests on wheelchairs when residents are being pushed by staff for mobilization. All staff will be educated on the use of wheelchair leg rests when a resident is being pushed by a staff member. Assistant Director of Nursing or designee will monitor random observation of staff when pushing wheelchairs daily x2 weeks, then weekly x 2 weeks, then monthly. Results to Quality Assurance.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **12/29/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

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P 5380	Continued from page 1 Based on observations, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that there was a written policy in place for the use of footrests on wheelchairs during transportation. Findings include: Observations of Resident 20 on December 4, 2023, at 12:20 p.m. revealed that staff pulled the resident in her wheelchair from the hall into the dining room area. Her wheelchair did not have footrests and her feet were dangling from the chair. Observations of Resident 34 on December 4, 2023, at 11:30 a.m. revealed that staff pushed the resident in her wheelchair from her room to the shower room down the hall. Her wheelchair did not have footrests and her feet were dangling from the chair. Interview with the Nursing Home Administrator on December 7, 2023, at 1:49 p.m. confirmed that the	P 5380		

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P 5380	Continued from page 2 facility did not have a policy regarding the use of footrests on wheelchairs for transportation.	P 5380		
P 5510	Nursing services. (2) Effective July 1, 2023, a minimum of 1 nurse aide per 12 residents during the day, 1 nurse aide per 12 residents during the evening, and 1 nurse aide per 20 residents overnight. This REGULATION is not met as evidenced by:	P 5510	The facility maintained nursing hours to meet state requirements of 2.87. The ratio template does not account for partial shifts or partial assignments. The facility offers shift bonuses to employees and a recruitment campaign is ongoing including sign-on bonuses, increased wages, increased shift differentials and employee referral bonuses. The Nursing Home Administrator will review with the Director of Nursing the latest guidelines for staffing ratios. The Nursing Home Administrator and Director of Nursing will meet to review daily staffing sheets to daily x5, weekly x2, then monthly with reports to Quality Assurance.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

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MULBERRY HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **021802**	**411 1/2 WEST MAHONING STREET PUNXSUTAWNEY, PA 15767**

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P 5510	Continued from page 3 Based on review of nursing schedules, staffing information provided by the facility, and staff interviews, it was determined that the facility failed to ensure a minimum of one nurse aide per 12 residents on the day shift for six of 21 days, failed to ensure a minimum of one nurse aide per 12 residents on the evening shift for three of 21 days, and failed to ensure one nurse aide per 20 residents on the overnight shifts for 19 of 21 days (24-hour periods) reviewed. Finding include: Nursing time schedules provided by the facility for the days of November 16 through December 6, 2023, revealed that the facility provided one nurse aide per 15 residents on November 18, 19 and 20, 2023 and December 3, 2023, and provided one nurse aide per 16 residents on November 25 and 18, 2023, during the day shift. Nursing time schedules provided by the facility for	P 5510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395618	A. BLDG: 00 B. WING:	12/07/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 5510	Continued from page 4 the days of November 16 through December 6, 2023, revealed that the facility provided one nurse aide per 15 residents on November 18 and 19, 2023, and provided one nurse aide per 16 residents on November 25, 2023, during the evening shift. Nursing time schedules provided by the facility for the days of November 16 through December 6, 2023, revealed that the facility provided one nurse aide per 22 residents on November 16, 2023; provided one nurse aide per 23 residents on November 17, 18 and 20, 2023 and December 1, 2 and 4, 2023; and provided one nurse aide per 24 residents on November 21, 22, 23, 24, 25, 26, 27 and 29, 2023 and December 5, 2023, during the overnight shift. Interview with the Nursing Home Administrator on December 7, 2023, at 3:30 p.m. confirmed that the facility did not meet the required nurse aide-to-resident staffing ratios for the days listed above	P 5510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility is utilizing Registered Nurses in lieu of Licensed Practical Nurses due to nursing shortage and inability to successfully hire new candidates. For example, The facility is providing one Licensed Practical Nurse and one Registered Nurse during the night shift for the current census of approximately 45 residents. Qualified members of the Facility Management team are also supplementing needed openings. The facility is offering shift bonuses and has implemented recruiting initiatives including sign-on bonuses, increased wages, increased shift differentials, and employee referral bonuses. Admissions from the community are being limited due to nursing limitations. The Nursing Home Administrator and the Director of Nursing will review the current guidelines for staffing ratios. A review of the daily staffing sheets will be completed daily x5, weekly x2, then monthly to help ensure compliance. Results to Quality Assurance.	Completion Date: **02/05/2024** Status: **APPROVED** Date: **01/02/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 6 Based on review of nursing schedules, staffing information provided by the facility, and staff interviews, it was determined that the facility failed to ensure a minimum of one licensed practical nurse (LPN) per 25 residents on the day shift for one of 21 days, failed to ensure one LPN per 30 residents on the evening shift for 10 of 21 days, and failed to ensure a minimum of one LPN per 40 residents on the overnight shift for 21 of 21 days (24-hour periods) reviewed. Findings Include: Nursing time schedules provided by the facility for November 16 through December 6, 2023, revealed that during the day shift the facility provided one LPN per 46 residents on November 19, 2023. Nursing time schedules provided by the facility for November 16 through December 6, 2023, revealed that during the evening shift the facility provided one LPN per 46 residents on November 19 and 20,	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 7 2023, and December 2 and 4, 2023; provided one LPN per 47 residents on November 29 and 30, 2023 and December 5, 2023; and provided one LPN per 48 residents on November 21, 23 and 26, 2023. Nursing time schedules provided by the facility for November 16 through December 6, 2023, revealed that during the overnight shift the facility provided one LPN per 44 residents on November 16, 2023; provided one LPN per 45 residents on November 17, 2023; provided one LPN per 46 residents on November 18, 19 and 20 and December 1, 2, 3 and 4, 2023; provided one LPN per 47 residents on November 27, 28, 30, 2023, and December 5 and 6, 2023; and provided one LPN per 48 residents on November 21, 22, 23, 24, 25, 26 and 29, 2023. Interview with the Nursing Home Administrator on December 7, 2023 at 3:30 p.m. confirmed that the facility did not meet the required LPN-to-resident staffing ratios for the days listed above.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395618	A. BLDG: __00_____ B. WING: _____	12/07/2023

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P 5530	Continued from page 8	P 5530		

Certified End Page

MULBERRY HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 021802

SURVEY EXIT DATE: 12/07/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY